MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05835

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year, 3 months, 15 days
Hospital, Institution, or street address where death occurred:
MARYLAND TUBERCULOSIS SANATORIUM COLORED BRANCH, HENRYTON, MD.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Worcester
City or town: Snow Hill
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: ELNORA ANTHONY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	married

6.(b) Name of husband or wife: Fred Anthony
6.(c) If alive, give age: 57 years

7. Birth date of deceased (mo., day, yr.): December 9, 1898

8. AGE:

Years	Months	Days	If less than one day
47	6	18	....hrs. ....min.

9. Birthplace: Shadboro, N.C.
(Town, county, and state)
10. Usual occupation: Worker in Canning Factory.
11. Industry or business

FATHER
12. Name: Skinner Walker
13. Birthplace: Unknown

MOTHER
14. Maiden name: Emma Lamb
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-30-46 (month) (day) (year)
Cemetery or crematory: Snow Hill Cemetery
Location: Snow Hill Md.
18. Funeral director: Hearne & Dennis
Address: Snow Hill Md.

19. June 27, 1946 (Date rec'd by registrar) Albert B. Smallwood Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 27, 1946, at 6:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 12, 1945, to June 27, 1946
and that I last saw her alive on June 27, 1946

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1944
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op.....
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M. D.
M. D. or other
Address: Henryton, Md. Date signed: 6-27-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-1

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05836

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 20 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1347 N. Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: ARTHUR BANKS

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 28, 1919

8. AGE: Years: 27 Months: 2 Days: 23 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER — 12. Name: Grover Banks
13. Birthplace: Glouster County, Va.

MOTHER — 14. Maiden name: Beulah Williams
15. Birthplace: Luenburg County, Va.

16. Informant: Deceased
Address:

17. Burial. (Burial, cremation, or removal. Which?) Date thereof 6-26-46 (month) (day) (year)
Cemetery or crematory: Mt. Auburn
Location: Baltimore City
18. Funeral director: Geo. G. Kelson
Address: 1303 Presstman St.

19. 6/21 19 46 (Date rec'd by registrar) Albert R. Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 19 46, at 10.00P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1, 19 46 to June 21 19 46 and that I last saw h. 1m alive on June 21, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1945
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 6/21/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05837

CERTIFICATE OF DEATH

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 28 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 109 S. Bond Street
(If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: GEORGE ALEXANDER BANKS

3.(b) Social Security Number: 212-12-7720

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 12, 1903

8. AGE: Years	Months	Days	If less than one day
43	0	19	hrs. min.

9. Birthplace: Annapolis, Md. (Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business

FATHER
12. Name: Ellias Dishroom
13. Birthplace: Annapolis, Md.

MOTHER
14. Maiden name: Lula Turner
15. Birthplace: Annapolis, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5, 1946 (month) (day) (year)
Cemetery or crematory: Mt Calvary Cem
Location:
18. Funeral director: Elroy O. Wilson
Address: 1000 Brantley ave

19. 6/1 (Date rec'd by registrar) 19 46 Albert R Swanborn Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1, 19 46 at 9.30A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3, 19 46 to June 1, 19 46 and that I last saw him alive on June 1, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Aug. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W Fuman M.D. M. D. or other
Address: Henryton, Md Date signed: 6/1/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05838 Y

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr 9 days

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 1 yr 9 dd

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4004 Northern Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Mary E Bauman

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Phillip C Bauman

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7th - 1867

8. AGE:

Years	Months	Days	If less than one day
78	11	17	hrs. min.

9. Birthplace: Baltimore Md (town, county, and state)

10. Usual occupation: housewife

11. Industry or business:

FATHER — 12. Name: William Ostendorf

13. Birthplace: Md.

MOTHER — 14. Maiden name: Mary —

15. Birthplace: Md

16. Informant: E. Harry Bauman Balto

Address: 4004 Northern Parkway

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/20/46 (month) (day) (year)

Cemetery or crematory: New Cathedral

Location: Old Frederick Rd

18. Funeral director: Mark H. Riggle's Sons

Address: 7110 Belair Rd

19. 6/19 1946 (Date rec'd by registrar) A.W. Hedrick Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 17th 1946, at 6 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 th 1945, to June 17, 1946

and that I last saw h alive on June 17th 1946

Immediate cause of death: Cerebral Hemorrhage — DURATION: 24 hrs

Due to: —

Due to: Ch. Myocarditis — DURATION: 10 yrs.

Other conditions: Hypertension —

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. E. Gaston M.D. M. D. or other

Address: Sykesville Md Date signed: 6/17/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

05839 8

Reg. Dist. No. 74

1. PLACE OF DEATH:
County Carroll
City or town Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 days
Hospital, Institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 10 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Baltimore
City or town Towson
(If outside city or town limits, write RURAL and give nearest town)
Street No. York Road
(If rural, give LOCATION)
2.(a) If veteran, name war ---

3.(a) FULL NAME CHARLES HERBERT BELL

3.(b) Social Security Number ---

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	separated

6.(b) Name of husband or wife Ethel Overcash
6.(c) If alive, give age unkn years

7. Birth date of deceased (mo., day, yr.) October 31, 1884

8. AGE: Years	Months	Days	If less than one day
61	8	8	....hrs. ....min.

9. Birthplace Baltimore, Md. (Town, county, and state)
10. Usual occupation laborer retired
11. Industry or business unknown gardener
FATHER 12. Name Charles Herbert Bell
13. Birthplace Penna.
MOTHER 14. Maiden name Sally Gordo n
15. Birthplace Penna.
16. Informant Hospital records
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 11, 1946 (month) (day) (year)
Cemetery or crematory Trinity Episcopal Cem.
Location Long Green, Balto. Co., Md.
18. Funeral director John Burns Sons
Address Towson, Maryland
19. 6-11-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 8 1946, at 6:00p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 1946, to June 8 1946 and that I last saw him alive on June 8 1946

Immediate cause of death	DURATION
Chronic Myocarditis	unkn
Due to Generalized Arteriosclerosis	unkn
Due to Fracture of orbital bone, due to an accidental fall. C.W.O.	
Other conditions Central Nervous System Syphilis (Include pregnancy within 3 months of death)	unkn.

~~Major findings of operation~~ Also, laceration of the posterior parietal region. Date of op.
Autopsy results Pulmonary Embolism; Fracture of orbital bone
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of May 31st, 1946
Where did injury occur? Sykesville, (City or town) Carroll, (County) Maryland (State)
Injured at home, farm, industry, public place (where?) Springfield State Hospital
Means of injury fell, while under sedation. Injured at work?

23. SIGNATURE Arnold H. Eichert M.D.
M. D. or other
Address Sykesville, Md. Date signed 6-8-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (34)

05840

CERTIFICATE OF DEATH

★ Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 hours
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Charles Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JOHN HENRY BLACK

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	col.	married

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): February ? 1901

8. AGE:	Years	Months	Days	If less than one day
	45	?	?	hrs. min.

9. Birthplace: Westminster, Md.
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: John Black
13. Birthplace: Westminster, Md.
MOTHER 14. Maiden name: Unknown
15. Birthplace: Unknown
16. Informant: Deceased
Address:
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 17 1946 (month) (day) (year)
Cemetery or crematory: Western Chapel
Location: near Westminster, Md
18. Funeral director: J. S. Myers, Jr.
Address: Westminster, Md.
19. June 13, 1946 (Date rec'd by registrar) Albert R. Swankhamer Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 13, 1946, at 10:40 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 13, 1946, to June 13, 1946 and that I last saw him alive on June 13, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Unknown
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Hyman, M.D.
Address: Henryton, Md.
M. D. or other
Date signed: 6-13-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (740)

05841

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:
County: Carroll
City or town: Middleburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: County:
City or town:
(If outside city or town limits, write RURAL and give nearest town)
Street No.:
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Violet Pearl Bowman

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Married

8.(b) Name of husband or wife: John H. Bowman
8.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Oct. 31, 1883

8. AGE: Years	Months	Days	If less than one day
62	7	13	hrs. min.

9. Birthplace: Md
(Town, county, and state)
10. Usual occupation: Housdwife
11. Industry or business

FATHER
12. Name: Samuel G. Minnick
13. Birthplace: Md

MOTHER
14. Maiden name: Ella Burgess
15. Birthplace: Md

16. Informant: John H. Bowman
Address: Middleburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 17 1946 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Middleburg, Md.

18. Funeral director: C. O. FUSS & SON
Address: Taneytown, Md.

19. June 16 1946 (Date rec'd by registrar) Janey M. Diver. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 14 19 46 at 3:45 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary occlusion	
Due to:	
Due to:	
Other conditions: —	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.:
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: — Injured at work?

23. SIGNATURE: James T. Marsh, Deputy Medical Examiner
M. D. or other
Address: Westminster, Md. Date signed: June 14-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83

CERTIFICATE OF DEATH

Reg. Dist. No. 05842 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21yrs 10mo--8 da.

Hospital, Institution, or street address where death occurred:

Springfield State Hospital

How long in hospital or institution? 21yrs--10mo--8 da

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 1620 North Gilmor Street

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Mary E. Broessel

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: William Broessel

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): November 14, 1868

8. AGE: Years	Months	Days	If less than one day
77	7	8	hrs. min.

9. Birthplace: Washington D.C. (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: unknown

FATHER — 13. Birthplace: unknown

MOTHER — 14. Maiden name: unknown

MOTHER — 15. Birthplace: unknown

16. Informant: Hospital Records

Address: Sykesville, Maryland.

17. Burial (Burial, cremation, or removal, Which?) Date thereof 6-28-46 (month) (day) (year)

Cemetery or crematory: Springfield Hosp. Cem.

Location: Sykesville, Md.

18. Funeral director: C. Harry Weer

Address: Sykesville, Md.

19. June 28 1946 (Date rec'd by registrar) C. Harry Weer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 22 1946, at 8.15 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1st 1946, to June 22 1946 and that I last saw her alive on June 21st 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	3 days
Due to:	
Due to: Cerebral Arteriosclerosis	16 years
Other conditions: Paranoid Condition	22 years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. Maud M. Rees M. D. or other

Address: Sykesville Md. Date signed: 6-22-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (466)

CERTIFICATE OF DEATH

★ Reg. Diat. No. 05843

1. PLACE OF DEATH:

County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Union Bridge

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Virginia L. Brooks

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Married.

6.(b) Name of husband or wife: Harvey Brooks

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 29 - 1869

8. AGE:

Years	Months	Days	If less than one day
77	8	25	..... hrs. ..... min.

9. Birthplace: Carroll Co Maryland.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home.

FATHER

12. Name: Not Known

13. Birthplace: Not Known.

MOTHER

14. Maiden name: Alice Elder

15. Birthplace: Maryland.

18. Informant: Mrs Rebecca Brown

Address: Union Bridge Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27-1946 (month) (day) (year)

Cemetery or crematory: Mt Joy

Location: Union Bridge Maryland

18. Funeral director: D D Hafer & Son

Address: Union Bridge & New Windsor Md

19. June 25 1946 (Date rec'd by registrar) R. Eichman Deputy Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1946, at 11.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1946 to June 24 1946

and that I last saw h.. alive on June 24 1946

Immediate cause of death	DURATION
Cancer - Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: I. H Legg M. D. or other

Address: Union Bridge Date signed: 6-25-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH NON-FADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 05844 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 24 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 731 N. Spring Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: LEROY CAMPBELL

3.(b) Social Security Number: 212-20-0151

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 28, 1923

8. AGE: Years: 22 Months: 7 Days: 23 If less than one day: hrs. min.

9. Birthplace: Baltimore, Md. (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Robert Campbell
13. Birthplace: Baltimore, Md.

MOTHER
14. Maiden name: Mary (Unknown)
15. Birthplace: Unknown

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-24-46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary cem.
Location: Anne Arundel County

18. Funeral director: Byron & Marie Wright
Address: 72 Craigsmith St.

19. 6/21 (Date rec'd by registrar) 19 46 Albert R. Swanbaum Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21, 19 46 at 11.50A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 27, 19 46 to June 21, 19 46 and that I last saw him alive on June 21, 19 46

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Sept. 1945
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Eileen Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 6/21/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUN 24 1946
BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05845

Reg. Dist. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 9 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Brandywine
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: IRENE MONROE CHESLEY

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: Moses Chesley
6.(c) If alive, give age: 30 years

7. Birth date of deceased (mo., day, yr.): November 22, 1919

8. AGE: Years	Months	Days	If less than one day
26	6	27	hrs. min.

9. Birthplace: Malcolm, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Sinclair Monroe
13. Birthplace: Malcolm, Md.

MOTHER
14. Maiden name: Florence Hawkins
15. Birthplace: Acquasco, Md.

16. Informant: Deceased
Address: Waedorf, Md R.F.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/22/46 (month) (day) (year)
Cemetery or crematory: St. Peter's
Location: Waedorf, Md
18. Funeral director: Arentt & Ryon
Address: Woodbridge, Md.

19. 6/19 (Date rec'd by registrar) 1946 Albert R. Brandham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 19, 1946, at 8.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10, 1946, to June 19, 1946
and that I last saw her alive on June 19, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 7, 1946
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben W. Oman, M.D.
M. D. or other
Address: Henryton, Md. Date signed 6/19/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 11584 1

1. PLACE OF DEATH:
County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Union Bridge
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jesse Edgar Clary

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mrs Isabel S Clary
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): November 10 1866

8. AGE: Years	Months	Days	If less than one day
79	7	13	____ hrs. ____ min.

9. Birthplace: Frederick County Maryland
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Retired
FATHER 12. Name: Jesse Clary
13. Birthplace: Maryland
MOTHER 14. Maiden name: Susanna Dudderar
15. Birthplace: Maryland
16. Informant: Mrs Isabel S Clary
Address: Union Bridge Maryland
17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 25-1946 (month) (day) (year)
Cemetery or crematory: Linganore Cemetery
Location: Unionville, Maryland
18. Funeral director: D.D.Hartzler & Sons
Address: Union Bridge & New Windsor Md
19. June 24 1946 (Date rec'd by registrar) Richman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1946 at 12.15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 2 1946 to June 23 1946 and that I last saw him alive on June 23 1946

Immediate cause of death	DURATION
Cancer Stomach	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ____ Injured at work?

23. SIGNATURE: J H Legg M. D. or other
Address: Union Bridge Md Date signed 6-23-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

05847

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46)

CERTIFICATE OF DEATH

Reg. Dist. No. 81

1. PLACE OF DEATH:

County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Lifetime

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Union Bridge
(If outside city or town limits, write RURAL and give nearest town)

Street No. Bark Hill
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William Edward Coleman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mrs. Daisy May Coleman

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) November 11 1865

8. AGE: Years 80 | Months 7 | Days 14 | If less than one day ..... hrs. ..... min.

9. Birthplace Frederick County Maryland
(Town, county, and state)

10. Usual occupation Engine Hostler (Cement Mill)

11. Industry or business Retired

FATHER
12. Name Samuel Coleman
13. Birthplace Maryland

MOTHER
14. Maiden name Sevia Catherine Albaugh
15. Birthplace Maryland

16. Informant Mrs. Daisy M. Coleman
Address Union Bridge Md R. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 28-1946 (month) (day) (year)

Cemetery or crematory Pipe Creek Cemetery

Location near Uniontown Maryland

18. Funeral director D. D. Hartle & Sons

Address Union Bridge & New Windsor Rd.

19. June 26 1946 (Date rec'd by registrar) P. Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 1946 at 12.10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1946, to June 25 1946

and that I last saw him alive on June 24 1946

Immediate cause of death Hemorrhage of stomach — DURATION

Due to

Due to Probable Cancer

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. H. Legg M. D. or other

Address Union Bridge Date signed 6-25-46

VS A15 9.45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

05848

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs. 7 mo. 10 da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4 yrs. 7 mo. 10 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Washington

City or town: Hagerstown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Alice Virginia Daugherty

3. (b) Social Security Number:

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
F	W	Married

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Sept. 14 - 1866

8. AGE: Years: 80 | Months: 8 | Days: 20 | If less than one day: hrs. min.

8. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER — 12. Name: Jacob Ritzmiller

FATHER — 13. Birthplace: Md.

MOTHER — 14. Maiden name: Virginia Stigers

MOTHER — 15. Birthplace: Maryland

18. Informant: Howard J. Daugherty

Address: Hillsboro, Md. Route 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6 - 6 - 46 (month) (day) (year)

Cemetery or crematory: Mason Cemetery

Location: Mt. Lebanon, Washington Co., Md.

18. Funeral director: Wm. F. Beard & Sons

Address: Boonsboro, Md.

19. June 3 1946 (Date rec'd by registrar) A. Henry Zeller, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 d 1946, at 2 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24 1941, to June 3 1946, and that I last saw h alive on June 3 d 1946

Immediate cause of death	DURATION
Cerebral Hemorrhage	Instn.
Due to	
Due to Arteriosclerosis	
Other condition Asthma	10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. Gaston Gill M. D. (M. D. or other)

Address: Sykesville Md. Date signed: 6/3/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

CERTIFICATE OF DEATH

05847 Reg. Dist. No. 76

1. PLACE OF DEATH:
County: Carroll
City or town: near Finksburg (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred: Hale Nursing Home
How long in hospital or institution? 8 months

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: near Finksburg (If outside city or town limits, write RURAL and give nearest town)
Street No.: Deer Park Road (If rural, give LOCATION)
2.(a) If veteran, name war: No

3.(a) FULL NAME: Mary Elizabeth Devese
3.(b) Social Security Number: None

4. Sex: F
5. Color or race: W
6.(a) Single, married, widowed, or divorced: W
6.(b) Name of husband or wife: John N. Devese
6.(c) If alive, give age .... years
7. Birth date of deceased (mo., day, yr.): June 18 1869
8. AGE: Years 76 Months 11 Days 21 If less than one day ...... hrs. ...... min.
9. Birthplace: Cockeysville-Balto Co-Md (Town, county, and state)
10. Usual occupation: Retired Housewife
11. Industry or business: -
FATHER 12. Name: William H. Fishpaw
13. Birthplace: Phoenix Md
MOTHER 14. Maiden name: Margaret E. Wilson
15. Birthplace: Phoenix Md
16. Informant: William Devese
Address: Reisterstown Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-11-46 (month) (day) (year)
Cemetery or crematory: Druid Ridge Cemetery
Location: Pikesville Md
18. Funeral director: Wm Berryman & Sons
Address: Reisterstown Md
19. 6/10 (Date rec'd by registrar) 19.... [illegible signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/9/46 19...., at 1 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-45 19...., to 6/9/46 19....
and that I last saw her alive on 6/8/46 19....

	DURATION
Immediate cause of death: Uremic Coma	
Chronic interstitial nephritis. Duration one year.	
Due to: hypertension [illegible]	
Due to: arteriosclerosis	
Other conditions: arthritis	

(Include pregnancy within 3 months of death)
Major findings of operations: —
Date of op.: —
Autopsy results: ....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: ✓
Accident, suicide, or homicide: — Date of: ....
Where did injury occur? .... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ....
Means of injury .... Injured at work? ....

23. SIGNATURE: [illegible signature] M. D. or other
Address: Reisterstown Md Date signed: 6/9/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 45850 24

1. PLACE OF DEATH:
County Carroll
City or town Rural near Bells Mill (If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: R. 1 Union Bridge, Md
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 6 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Westminster Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 33 John St. (If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME Frances Missouri Shunk Riffendal

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Female	White	Widowed

6 (b) Name of husband or wife John H. Riffendal deceased 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) October 9, 1846

8. AGE: Years 99 | Months 8 | Days 16 | If less than one day hrs. min.

9. Birthplace Uniontown, Carroll Co., Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business own home

MOTHER FATHER
12. Name Samuel Shunk
13. Birthplace Carroll Co. Md
14. Maiden name Catherine Heiter
15. Birthplace Unknown

16. Informant Mrs. Nan Reutterer
Address 33 John St Westminster

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26/46 (month) (day) (year)
Cemetery or crematory Lutheran Cemetery
Location Taneytown, Md.

18. Funeral director J. S. Myers Jr.
Address Westminster Md.

19. June 26 1946 Margaret R. Englar
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 24 1946, at 5 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from October 1943 to June 24 1946 and that I last saw her alive on June 21 1946

Immediate cause of death Arteriosclerotic Myocardial degeneration — DURATION 1+ yrs

Due to

Due to

Other conditions Senile deterioration
Old fracture rt femur
(Include pregnancy within 3 months of death)

Major findings:
Of operations

Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

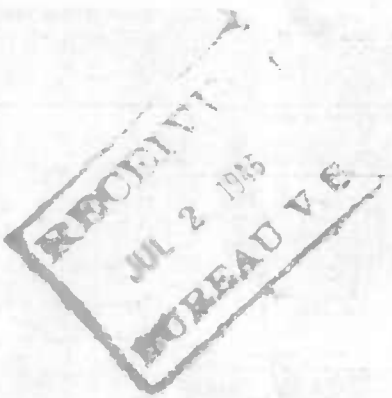
22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE E Reese Wolfsens M. D. or other
Address Westminster Md. Date signed 6/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15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BUREAU OF

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92d

CERTIFICATE OF DEATH

05851

Reg. Dist. No. 83

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Rural- Sykesville

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 2 years

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Rural --Sykesville Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: JOHN DORSEY

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Single

B (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): March 6, 1897

8. AGE: Years: 49 | Months: 3 | Days: 17 | If less than one day: hrs. min.

9. Birthplace: Carroll Co. Maryland (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business

FATHER — 12. Name: Joseph Dorsey

FATHER — 13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rebecca Hall

MOTHER — 15. Birthplace: Maryland

16. Informant: Mrs. Annie Groomes

Address: Sykesville, Md.

17. (Burial, ~~cremation, or removal~~. Which?) Burial — Date thereof 6- 26-46 (month) (day) (year)

Cemetery ~~or crematory~~: White Rock

Location: Berrett, Carroll Co. Md.

18. Funeral director: C. M. Waltz

Address: Winfield, Md.

19. (Date rec'd by registrar) June 26 1946 — Registrar: Edna M. Hewitt Deputy

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 23 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1945, to June 23 1946, and that I last saw him alive on June 23 1946.

Immediate cause of death	DURATION
Cerebral Embolism	
Endocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

PHYSICIAN

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: T. A. Bonner M.D.

M. D. or Other

Address: Ivy Knolls Md — Date signed 6/24/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

05852

CERTIFICATE OF DEATH

Reg. Diat. No. 76

1. PLACE OF DEATH:

County Carroll

City or town Rural Westminster

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Carroll

City or town Westminster

(If outside city or town limits, write RURAL and give nearest town)

Street No. 234 E. Main

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Catherine Evans

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife Joseph E. Evans

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 24 1861

8. AGE: Years	Months	Days	If less than one day
85	1	15	....hrs. ....min.

9. Birthplace Carroll Co. Md. (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER

12. Name Henry Richter

13. Birthplace Germany

MOTHER

14. Maiden name Not Known

15. Birthplace

16. Informant John H. Evans

Address 234 E. Main Westminster Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 12 1946 (month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Carroll Co. Md.

18. Funeral director H. Bankard & Son

Address Westminster Md.

19. 6/11 1946 (Date rec'd by registrar) [signature] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 9 1946 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 6 1946, to June 9 1946 and that I last saw h[illegible] alive on June 9 1946

Immediate cause of death	DURATION
Acute Cardiac Dilatation	5 hrs
Due to Chronic Interstitial Nephritis	5 yrs
Due to Senile Gangrene Left Arm	6 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Chas R. Fouke M.D. M. D. or other

Address Westminster Md. Date signed 6.11.46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73)

05853

CERTIFICATE OF DEATH

Reg. Dist. No. 79

1. PLACE OF DEATH:

County Carroll

City or town Keysville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 weeks

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Md. County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war ✓

3.(a) FULL NAME James N. Fox

3.(b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	widower

6.(b) Name of husband or wife Louise McKinney

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 29, 1856

8. AGE: Years	Months	Days	If less than one day
90	3	19	..... hrs. ..... min.

9. Birthplace Md.
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business

FATHER 12. Name Samuel D. Fox

13. Birthplace Md.

MOTHER 14. Maiden name Maryannx Young

15. Birthplace Md.

16. Informant T. C. Fox

Address Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 21, 1946. (month) (day) (year)

Cemetery or crematory Keysville

Location Keysville, Md.

18. Funeral director C. O. FUSS & SON

Address Taneytown, Md.

19. June 20 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 1946, at 1.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 5 1946, to June 18 1946 and that I last saw h.. l.. alive on June 18th 1946.

Immediate cause of death	DURATION
Chronic Myocarditis & Myocardial Degeneration	Years
Due to Chron Rheumatic	
Due to	
Other conditions Senile Arteriosclerosis Chronic Nephritis	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. S. McCaughy M. D.
M. D. or other

Address Taneytown, Md. Date signed 6/19/46

M

I

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

05854

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr. 7 mo's, 23 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1533 N. Gilmor Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: IRENE FRAZIER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 16, 1928

8. AGE:

Years	Months	Days	If less than one day
17	8	20	hrs. min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)
10. Usual occupation: Defense Worker
11. Industry or business:

FATHER
12. Name: Phillip Frazier
13. Birthplace: Calvert County, Md.

MOTHER
14. Maiden name: Nella Mae Shanks
15. Birthplace: Stone Creek, Va.

16. Informant: Deceased
Address:

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 10-1946 (month) (day) (year)
Cemetery or crematory: Mt Calvery Cem
Location: Baltimore Md
18. Funeral director: Elroy O. Wilson
Address: 1000 Bentley ave

19. 6/6 (Date rec'd by registrar) 19 46 Albert C. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 19 46, at 12.45P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 13, 19 44, to June 6, 19 46 and that I last saw her alive on June 6, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Sept. 1944
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Swan, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6/6/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-d)

CERTIFICATE OF DEATH

not CB

05855

Reg. Dist. No. 72

1. PLACE OF DEATH:
County Carroll
City or town Westminster R.D. 1 (Myers District)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 Years 3 Mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Penna County York
City or town Hanover.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 120 Ruth ave;
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ida Salome Houck

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Nelson T. Houck
6.(c) If alive, give age Dead years

7. Birth date of deceased (mo., day, yr.) July 23 1862

8. AGE:

Years	Months	Days	If less than one day
83	11	2	..... hrs. ..... min.

9. Birthplace Carroll Co. Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business Family Home.

MOTHER FATHER
12. Name Jacob Essich
13. Birthplace Carroll Co. Md.

MOTHER
14. Maiden name Susanna Baumgardner
15. Birthplace Carroll Co. Md
16. Informant Lottie V. Koontz,
Address Westminster, Md. R. D. 1

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27 1946 (month) (day) (year)
Cemetery or crematory Mt. Aliret Cemetery
Location Hanover. Penna.
18. Funeral director T. W. Lisle & Son
Address Littlestown, PA Reg. R. A. Lisle
19. June 25th 1946 (Date rec'd by registrar) Calvin D. Banker Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th 1946 at 12:10 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr. 1943 to June 25th 1946
and that I last saw her alive on June 24th 1946

	DURATION
Immediate cause of death Chronic Myocarditis	about 3 years
Due to Arteriosclerosis	
Due to Senility	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. B. Billingslea M. D. or other
Address Westminster, Md. Date signed 6-25-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 306

CERTIFICATE OF DEATH

★ 05856

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yr., 2 mo., 10 days
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 7 yr., 2 mo., 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If ontside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Jesse P. Hite

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Betty Elizabeth Hite
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 10, 1873

8. AGE: Years	Months	Days	If less than one day
73	2	24	hrs. min.

9. Birthplace: Cumberland, Maryland (Town, county, and state)
10. Usual occupation: Railroader
11. Industry or business:

FATHER
12. Name: George F. Hite
13. Birthplace: ?

MOTHER
14. Maiden name: Mary Ann ?
15. Birthplace: Liverpool, England

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 6, 1946 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland, Md.
18. Funeral director: Hafer's Funeral Home
Address: Cumberland, Md.

19. June 7 1946 (Date rec'd by registrar) C. Harry Weed Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 3 1946 at 11:28 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 1 1946, to June 3 1946 and that I last saw him alive on June 3 1946

Immediate cause of death	DURATION
Myocardial failure	Immediate
Due to: syphilis	about 10 yr.
Due to:	
Other conditions: Syphilitic meningo encephalitis	about 10 yr.

(Incinde pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the canse tn which death shnnld he charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Allan Burke, M.D. M. D. or other
Address: Springfield State Hospital Sykesville, Maryland Date signed 6-3-46

05857

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

Reg. Diat. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 Months, 1 Day
Hospital, institution, or street address where death occurred:
Springfield State Hospital
How long in hospital or institution? 5 Months, 1 Day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Owings Mills
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Pleasant Hill Park
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter S. Holland

3.(b) Social Security Number: 213-10-0137

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Ada Gover Holland (deceased) 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 7, 1874

8. AGE: Years: 71 Months: 8 Days: 1 If less than one day: ..... hrs. ..... min.

9. Birthplace: Maryland near Cambridge
(Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER
12. Name: William Holland
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ada Stablefort
15. Birthplace: Maryland

16. Informant: Springfield State Hosp. records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-11-46 (month) (day) (year)
Cemetery or crematory: Cambridge
Location: Cambridge, Md.

18. Funeral director: Ellis
Address: Reisterstown, Md.

19. June 9 1946 (Date rec'd by registrar) C. Harry Ebert Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8 1946 at 9:03 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 7 1946, to June 8 1946
and that I last saw him alive on June 8 1946

	DURATION
Immediate cause of death	
Arteriosclerosis	2 yr.
Due to	
Due to	
Other conditions: Psychosis with chronic alcoholism	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robert Bertrand May M.D.
Springfield State Hospital M. D. or Other
Address: Sykesville, Maryland Date signed: 6-8-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05858

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 1020 N. Arlington Avenue

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES HOOPER

3.(b) Social Security Number: 219-18-9857

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Lucille Hooper

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): March 15, 1920

8. AGE:

Years	Months	Days	If less than one day
26	3	14	..... hrs. ..... min.

9. Birthplace: Northumberland Co., Va. (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Unknown

FATHER

12. Name: Harry Hooper

13. Birthplace: Northumberland Co., Va.

MOTHER

14. Maiden name: Eva Carrady

15. Birthplace: Northumberland Co., Va.

16. Informant: Deceased

Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof 4/3/46 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location

18. Funeral director: George T. A. Gibson

Address: 1736 Druid Hill Ave

19. 6/29 19 46 (Date rec'd by registrar) Albert R. Swanbrow Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29, 19 46, at 6.16A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 19 46 to June 29, 19 46 and that I last saw him alive on June 29, 19 46

	DURATION
Immediate cause of death: Pulmonary Tuberculosis	Feb. 1946
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Reuben D. Owen M.D. M. D. or other

Address: Henryton, Md. Date signed: 6/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05859

Reg. Dist. No. 74

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

1. PLACE OF DEATH:
County Carroll
City or town Henryton,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 17 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Dorchester
City or town Cambridge
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 Park Lane
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JULIUS WARFIELD HOOPER

3.(b) Social Security Number 214-07-9540

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May (?) 1915

8. AGE: Years	Months	Days	If less than one day
31	1	?	hrs. min.

9. Birthplace Crapo, Md. (Town, county, and state)
10. Usual occupation Oyster Factory Worker
11. Industry or business

FATHER
12. Name Robert Hooper
13. Birthplace Maryland

MOTHER
14. Maiden name Eleanor Elliott
15. Birthplace Crapo, Md.

16. Informant Rebecca Hooper
Address Cambridge, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20 /46 (month) (day) (year)
Cemetery or crematory Crapo Methodist Cemetery
Location Crapo, Md.
18. Funeral director Lewis & Bateman
Address Cambridge, Md.

19. 6/17 (Date rec'd by registrar) 19 46 Albert R. Shanahan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 17, 1946 at 5.05A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30, 1946 to June 17, 1946 and that I last saw him alive on June 17, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to	
Due to	
Other conditions Diabetes Mellitus	

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Reuben A. Thomas M.D. M. D. or other
Address Henryton, Md. Date signed 6/17/46

05860

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (932)

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:

County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9 years

Hospital, Institution, or street address where death occurred:
Methodist Protestant Church Home

How long in hospital or institution? 9 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)

Street No.: E. Main & Church Sts.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Emma C. Hunter

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	widowed

6.(b) Name of husband or wife: Andrew M. Hunter

6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): August 8, 1857

8. AGE:	Years	Months	Days	If less than one day
	88	9	30	____ hrs. ____ min.

9. Birthplace: Baltimore, Md.
(Town, county, and state)

10. Usual occupation: none

11. Industry or business:

FATHER
12. Name: John J. B. Bregel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Madeleine Loeffler
15. Birthplace: Maryland

16. Informant: Mrs. George Mather
Address: Westminster, Md.

17. burial (Burial, cremation, or removal. Which?) Date thereof 6/11/46 (month) (day) (year)

Cemetery or crematory: Baltimore Cemetery

Location: Baltimore, Md.

18. Funeral director: J. Francis Reese

Address: Westminster, Md.

19. 6/6 (Date rec'd by registrar) 19 46 L. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7 19 46 at 7.15p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19 40 to June 7 19 46 and that I last saw h[illegible] alive on June 6 19 46

Immediate cause of death: Cerebral Thrombosis

DURATION: 3 days

Due to: Arteriosclerosis 9 yrs

Due to: ____

Other conditions: Chronic Myocarditis 9 yrs

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____

Autopsy results: ____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE: [illegible] M. D. or Coroner

Address: Westminster Date signed: 6/8/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05861 74

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Carroll

City or town: Henryton (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 months, 15 days

Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 1005 N. Arlington Ave. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: MARY VIOLA HUNTER

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): April 8, 1926

8. AGE: Years	Months	Days	If less than one day
20	2	0	hrs. min.

9. Birthplace: Virginia (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER 12. Name: Charles Hunter

FATHER 13. Birthplace: Virginia

MOTHER 14. Maiden name: Mary Lee

MOTHER 15. Birthplace: Virginia

16. Informant: Deceased

Address

17. (Burial, cremation, or removal. Which?) Date thereof: 6-11-46 (month) (day) (year)

Cemetery or crematory: Mt. Auburn

Location: Baltimore City

18. Funeral director: Geo. T. Kelson

Address: 1308 Preston St.

19. June 8, 1946 (Date rec'd by registrar) Albert R. Swanson Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 8, 1946, at 1:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 23, 1946 to June 8, 1946 and that I last saw her alive on June 8, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman M.D. M. D. or other

Address: Henryton, Md. Date signed: 6-8-46

05862

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 14 days
Hospital, Institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Prince George's
City or town: Lakeland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5118 Navajo Ave.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: MARY VIRGINIA JOHNSON

3.(b) Social Security Number: 579-34-6924

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	col.	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): February 13, 1928

8. AGE: Years: 18 | Months: 3 | Days: 23 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Lakeland, Md. (Town, county, and state)

10. Usual occupation: Maid

11. Industry or business

FATHER
12. Name: Clifton Johnson
13. Birthplace: Lakeland, Md.

MOTHER
14. Maiden name: Grace Lancaster
15. Birthplace: Montgomery County, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 8 1946 (month) (day) (year)
Harmony Cemetery or crematory Colesville Md
Location Ford Hobbs
18. Funeral director Robert L. Snowden
Address Rockville Md

19. June 6, 1946 (Date rec'd by registrar) Albert R. Shankham Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 6, 1946 at 6:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 22, 1946 to June 6, 1946 and that I last saw h...er alive on June 6, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben W. Swan M.D. M. D. or other
Address: Henryton, Md. Date signed: 6-6-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

05863 75
Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Carroll
City or town: Manchester
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME JOANNA FISHEL KREBS

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Peiss Krebs
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): April 14 1867

8. AGE: Years 79 | Months 1 | Days 20 | If less than one day: hrs. min.

9. Birthplace: York Co Pa
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER 12. Name: John Fishel
13. Birthplace: York Co. Pa
MOTHER 14. Maiden name: Jayton
15. Birthplace: York Co. Pa.
16. Informant: Vernon K. Krebs
Address: Manchester Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 7 1946 (month) (day) (year)
Cemetery or crematory: Stone Church
Location: Brodbecks, Pa
18. Funeral director: H. Geipel
Address: Glen Rock, Pa
19. June 6 1946 Mrs. W. R. S. Benner
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4 1946 at 1.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 1942 to June 3 1946 and that I last saw h alive on June 3 1946

Immediate cause of death: Chronic myocarditis and myocardial degeneration — DURATION: 10 yrs.
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Louis Schatanoff M.D
M. D. or other
Address: New Freedom, Pa Date signed 6-4-46

05864

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B6-a)

CERTIFICATE OF DEATH

★ Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Westminster (Outside city limits)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, institution, or street address where death occurred:
Carroll County Home
How long in hospital or institution? 15 years

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster, R.D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Phillip Kraft

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married

6.(b) Name of husband or wife unknown
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) 3-15-61

8. AGE: Years	Months	Days	If less than one day
85	3	3	hrs. min.

9. Birthplace Maryland
(Town, county, and state)
10. Usual occupation Chair Caner
11. Industry or business Furniture
12. FATHER Name Phillip Kraft
13. Birthplace Germany
14. MOTHER Maiden name Catherine Baugh
15. Birthplace Germany
16. Informant Deceased, some years before his death
Address
17. Burial, cremation, or removal? Date thereof 6-20-46 (month) (day) (year)
Cemetery or crematory Baltimore
Location Westminster, Md
18. Funeral director Jacob Winks & Son
Address Manchester, Md.
19. 6/15 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1946 at 11 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Head injuries + shock (no attendance)	4 days
Due to	
Due to	
Other conditions Senility	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide accident Date of 6-14-46
Where did injury occur? Near Westminster, Md.
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?) County Home
Means of injury Fell down steps Injured at work? no

23. SIGNATURE C. Billingslea, M.D.
M. D. or other
Address Westminster, Md. Date signed 6-18-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (40)

05865

CERTIFICATE OF DEATH

★ Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Rural near Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death: 21 yr., 3 mo., 15 days

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 21 yr., 3 mo., 15 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore City
(If outside city or town limits, write RURAL and give nearest town)

Street No.:
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Edwin Mark

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Addie

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 9, 1857

8. AGE: Years	Months	Days	If less than one day
89	3	19	hrs. min.

9. Birthplace: Baltimore City, Maryland
(Town, county, and state)

10. Usual occupation: clerk (bookkeeper)

11. Industry or business:

FATHER
12. Name: William T. Mark
13. Birthplace: Baltimore County, Maryland

MOTHER
14. Maiden name: Elizabeth Butler
15. Birthplace: Baltimore County, Maryland

16. Informant: Springfield State Hospital Records
Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6-29-46 (month) (day) (year)

Cemetery or crematory: London Park Cem.

Location: Balto. Md.

18. Funeral director: H. Burgee

Address: Falls Road, Balto. Md.

19. June 29 1946 (Date rec'd by registrar) C. Henry Zeck Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 28 1946, at 7:40a M

21. I CERTIFY that death occurred on the date above stated: That I attended deceased from May 1 1943 to June 28 1946 and that I last saw him alive on June 27 1946

Immediate cause of death	DURATION
Coronary occlusion	12 hrs.
Due to: Senility	13 yrs.
Due to:	
Other conditions: Manic-depressed psychosis, depressed type	21 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

Robert Bertrand May, M.D.

23. SIGNATURE: Robt Bertrand May, M.D.

Springfield State Hospital
Address: Sykesville, Maryland

M. D. or other

Date signed: 6-28-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

05866

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1627 Ashland Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: JAMES MCCOY

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married

6.(b) Name of husband or wife: Gladys McCoy
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 30, 1889

8. AGE: Years 56 | Months 8 | Days 0 | If less than one day: hrs. min.

9. Birthplace: Wilmington, N. C.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Wade McCoy
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Gladys McCoy
Address: 1627 Ashland Ave.,

17. Burial, cremation, or removal. Which? Burial Date thereof (month) (day) (year) 7/4/46
Cemetery or crematory: Mt. Calvary
Location:

18. Funeral director: Robert C. Williams
Address: 1515 McElderry St.

19. 6/30 19 46 (Date rec'd by registrar)
Albert R. Swanborne Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 19 46, at 1.55P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 17, 19 46, to June 30, 19 46 and that I last saw her alive on June 30, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Dec. 1945
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Reuben Wolman, M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6/30/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

Reg. Diat. No. 058670

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Harney (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5 yrs.

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Harney (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marjorie M. C.. Ohler

3.(b) Social Security Number: ~~[illegible]~~196-05-6656

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 5, 1898

8. AGE: Years	Months	Days	If less than one day
48	1	19	..... hrs. ..... min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business

FATHER — 12. Name: John W. Ohler

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Rosie L. Stiffler

15. Birthplace: Penna.

16. Informant: Mrs. Raymond Reynolds

Address: Taneytown, Md. R.D.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 27, 1946 (month) (day) (year)

Cemetery or crematory: Evergreen Cemetery

Location: Gettysburg, Pa.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. June 26 1946 (Date rec'd by registrar) Ethel M Metzger Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: JUNE 24 19 46, at 7.45 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 17 19 46, to JUNE 24 19 46 and that I last saw h.. alive on JUNE 23 19 46

Immediate cause of death	DURATION
CANCER OF DIGESTIVE TRACT & PERITONEUM	8 MONTH
Due to: CANCER OF BREAST, LEFT.	1 YEAR
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: REMOVAL LEFT BREAST. ADENO-CARCINOMA Date of op. JULY 19, 1945

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: L. L. Potter M. D. (M. D. or other)

Address: Littlestown, Pa. Date signed: June 25, 1946

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

05868

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 month, 11 days
Hospital, institution, or street address where death occurred: Maryland Tuberculosis Sanatorium Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 626 N. Carey Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: ETTA PAYNE

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: James Payne
6.(c) If alive, give age: 45 years

7. Birth date of deceased (mo., day, yr.): February 25, 1906

8. AGE: Years	Months	Days	If less than one day
40	3	9	hrs. min.

9. Birthplace: Salisbury, N. C.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: at home

MOTHER FATHER
12. Name: Unknown
13. Birthplace: Unknown
MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Deceased
Address

17. Buried (Burial, cremation, or removal. Which?) Date thereof June 4/46 (month) (day) (year)
Cemetery or crematory: Salisbury N C
Location

18. Funeral director: Katie R. Williams
Address 322 N Schroeder

19. 6/4 (Date rec'd by registrar) 19 46 Albert R. Brambach Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 4, 19 46 at 9.00P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from April 23, 19 46 to June 4, 19 46
and that I last saw her alive on June 4, 19 46

Immediate cause of death: Pulmonary Tuberculosis — DURATION: Dec. 1945
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben W. Freeman M.D.
M. D. or other
Address: Henryton, Md. Date signed: 6/4/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05869

Reg. Diat. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 months, 12 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Baltimore
City or town: Catonsville
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9 Jones Avenue
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: IDA MAE QUARLES

3.(b) Social Security Number: 220-22-2679

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	colored	married

6.(b) Name of husband or wife: John Quarles
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 2, 1914

8. AGE:

Years	Months	Days	If less than one day
32	2	28	hrs. min.

9. Birthplace: Dayton, Md. (Town, county, and state)
10. Usual occupation: Hectographer
11. Industry or business

FATHER
12. Name: David A. Thorne
13. Birthplace: Dayton, Md.

MOTHER
14. Maiden name: Eliza Jane Clark
15. Birthplace: Dayton, Md.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 3, 1946 (month) (day) (year)
Cemetery or crematory: Brown's Chapel
Location: Dayton, Md.
18. Funeral director: Kate R. Willan
Address: 522 Shoreder Street

19. 6/30 (Date rec'd by registrar) 1946 Albert R. Swankhaus Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 30, 1946, at 4.30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 18, 1946, to June 30, 1946 and that I last saw her alive on June 30, 1946

Immediate cause of death	DURATION
Pulmonary Tuberculosis	Jan. 1946
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address: Henryton, Md. Date signed: 6/30/46

VS A15 9-45-15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (462)

05870

CERTIFICATE OF DEATH

Reg. Dist. No. 81

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 5-45-15M

1. PLACE OF DEATH:
County: Carroll
City or town: Middleburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Middleburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mary Lynn Reisler

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Jesse Reisler
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): October 13-1870

8. AGE: Years	Months	Days	If less than one day
75	8	16	..... hrs. ..... min.

9. Birthplace: Carroll County Maryland
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home

FATHER
12. Name: Lewis F Lynn
13. Birthplace: Maryland

MOTHER
14. Maiden name: Emma G Haley
15. Birthplace: Maryland

16. Informant: Miss Grace Lynn
Address: Middleburg Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof July 1-1946 (month) (day) (year)
Cemetery or crematory: Mountain View Cemetery
Location: Union Bridge Maryland

18. Funeral director: D.D.Hartzler & Sons
Address: Union Bridge & New Windsor Md

19 June 30 19 46 (Date rec'd by registrar) H Eichman Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 29-1946 19 ..... at 6.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 28 1946 to June 28 1946 and that I last saw h[illegible] alive on June 28 1946

Immediate cause of death	DURATION
Cancer - Intestines	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: J. W. Lynn M. D. or other
Address: Union Bridge Date signed 6-29-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (51-C)

05871

CERTIFICATE OF DEATH

Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Cedarhurst
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll Co.
City or town: Cedarhurst
(If outside city or towo limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Edwin Rutter Remley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W.	M.

6.(b) Name of husband or wife: Catharine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 24-1869

8. AGE: Years 77 | Months | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace: Baltimore (Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Income Tax. Agent

FATHER
12. Name: William Henry Remley
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary A. Rutter
15. Birthplace: Va.

16. Informant: Catharine A Remley
Address: Cedarhurst. Carroll Co.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 20. 46 (month) (day) (year)
Cemetery or crematory: Mt Olivet Cem.
Location: Baltimore

18. Funeral director: Wm Cook Inc.
Address: 1217 St Paul st.

19. 6-19 46 (Date rec'd by registrar) 19 ..... Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 6/18/46 19 ..... at 12 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-44 19 ..... to 6-18-46 19 .....
and that I last saw h[illegible] alive on 6/18/46 19 .....

Immediate cause of death	DURATION
Angina Pectoris	2 yrs
Due to: Hypertension	
Due to: arteriosclerosis	
Other conditions: Carcinoma of prostate gland	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury ..... Injured at work? —

23. SIGNATURE: James L. Lahell M. D. or other
Address: Reisterstown Md Date signed 6/18/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

★ 05872

Reg. Dist. No. 74

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 11 yr. 0 mo. 2 da.

Hospital, institution, or street address where death occurred:
Springfield State Hospital

How long in hospital or institution? 11 yr. 0 mo 2 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1713 Bolton Street
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME

Elizabeth Cobb Richardson

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	wodowed

6.(b) Name of husband or wife: Ernest A. Richardson

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 20, 1869

8. AGE: Years	Months	Days	If less than one day
76	8	6	hrs. min.

9. Birthplace: Baltimore, Maryland
(Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER
12. Name: Charles H. Cobb
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Anne Emmert
15. Birthplace: Maryland

16. Informant: Hospital Records

Address: Sykesville Maryland

17. Cremation (Burial, cremation, or removal. Which?) Date thereof June 29 1946 (month) (day) (year)

~~Cemetery~~ or crematory: Greenmount

Location: Balto. Md.

18. Funeral director: William Cook, Inc.

Address: 1217 N. Paul St.

19. June 27 1946 (Date rec'd by registrar) C. Henry Lewis Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 26, 1946 at 9.15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 13 1937, to June 26 1946 and that I last saw her alive on June 26, 1946

Immediate cause of death	DURATION
General Arteriosclerosis	11 yrs
Due to:	
Due to:	
Other conditions: Psychosis with cerebral Arteriosclerosis	12 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured of home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Maud M. Rees M.D.
M. D. or other

Address: Sykesville Md Date signed 6-26-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B-P)

05873

CERTIFICATE OF DEATH

Reg. Diat. No. 76

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll Co.
City or town: Westminster (outside)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? all his life
Hospital, Institution, or street address where death occurred: 99 Liberty St. Extended
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Westminster
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 99 Liberty St. Ext'd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Joseph O'neill Rickell

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Widowed

6.(b) Name of husband or wife: Annie C. Beran Rickell — 6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): Jan 3. 1879

8. AGE:

Years	Months	Days	If less than one day
67	5	17	____ hrs. ____ min.

9. Birthplace: Westminster Carroll Co. Md. (Town, county, and state)
10. Usual occupation: Retired Cement Contractor
11. Industry or business
12. FATHER — Name: Adam Rickell
13. FATHER — Birthplace: Westminster, Carroll Co.
14. MOTHER — Maiden name: Mary C. Snyder
15. MOTHER — Birthplace: Carroll Co. Md.
16. Informant: Miss Anna B. Rickell
Address: 99 Liberty St. Westminster Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: 6/22/46 (month) (day) (year)
Cemetery or crematory: St. John's Cemetery
Location: Westminster Maryland
18. Funeral director: J. E. Myers, Jr.
Address: Westminster, Md.
19. 6/20 1946 (Date rec'd by registrar) L. K. Woodward Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20 1946, at 2 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1925 1946, to 6/20 1946
and that I last saw h— alive on June 19 1946
Immediate cause of death: Cerebral embolism — Duration: 4 days
Due to: Hypostatic pneumonia — 1 day
Due to: Tuberculosis — 20 yrs.
Due to: ____
Other conditions: Chronic Cystitis — 5 yrs
(Include pregnancy within 3 months of death)
Major findings of operations: ____ Date of op.: ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of: ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): ____
Means of injury: ____ Injured at work?

23. SIGNATURE: L. K. Woodward M. D. or other
Address: Westminster Date signed: 6/20/46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

05874

★ Reg. Diat. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH

County: Carroll

City or town: Manchester Md Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred:
Melrose

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Manchester Md Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Melrose
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Daniel Royer.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Martha Irene Royer

6.(c) If alive, give age: 73 years

7. Birth date of deceased (mo., day, yr.): June 18, 1868

8. AGE:

Years	Months	Days	If less than one day
77	11	27	...hrs. ...min.

9. Birthplace: Pennsylvania.
(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: Agriculture.

FATHER
12. Name: Isaac Royer
13. Birthplace: Maryland.

MOTHER
14. Maiden name: Mary Law.
15. Birthplace: Pennsylvania.

18. Informant: Russell E. Royer
Address: Manchester Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 14 1946 (month) (day) (year)

Cemetery or crematory: Black Rock Church

Location: Lineboro Md R.D.

18. Funeral director: H.C. Leppo.

Address: Glen Rock. Pa.

19. June 13 1946 Md. W.P.S. Denver Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 11 1946, at 8:50 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1, 1946, to June 11 1946 and that I last saw h... alive on June 11 1946

Immediate cause of death: Coute Pulmonary Edema

DURATION: 10 hrs.

Due to: Hypertension, Cardiac renal?
Arteriosclerosis

Due to: Generalized Arterio-Sclerosis?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Joseph E. Bankard M. D. or other

Address: Hampstead Md Date signed: 6-11-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74-a)

CERTIFICATE OF DEATH

05875

Reg. Dist. No. 70

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Taneytown

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Taneytown Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Harvey R. Shryock

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of ~~husband or~~ wife: Bertha E. Shryock

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 24, 1885

8. AGE: Years	Months	Days	If less than one day
61	2	27	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business

FATHER — 12. Name: John Shryock

13. Birthplace: Md.

MOTHER — 14. Maiden name: Catherine Anders

15. Birthplace: Md.

16. Informant: Drs. R. S. McVaugh

Address: Taneytown, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 24 1946 (month) (day) (year)

Cemetery or crematory: Keysville Cemetery

Location: Keysville, Md.

18. Funeral director: C. O. Fuss & Son

Address: Taneytown, Md.

19. June 22 1946 (Date rec'd by registrar) Ethel M. Mehring Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 21 1946, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h... alive on ....19....

Immediate cause of death	DURATION
Coronary occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ....Date of op....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ....Date of....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: James T. Marsh Deputy Medical Examiner M. D. or other

Address: Westminster Md. Date signed: June 21-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05876 Reg. Dist. No. 74

1. PLACE OF DEATH:
County: Carroll
City or town: Henryton
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 29 days
Hospital, institution, or street address where death occurred:
Maryland Tuberculosis Sanatorium
Colored Branch, Henryton, Md.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residance of mother)
State: Maryland County:
City or town: Baltimore
(If outside city or town limits, write RURAL and give nearest town)
Street No. 19 N. Spring Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: HENRY SQUARE

3.(b) Social Security Number: 217-12-5549

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	colored	married (Sep).

6.(b) Name of husband or wife: Ollie Square
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 15, 1898

8. AGE: Years	Months	Days	If less than one day
48	2	22	hrs. min.

9. Birthplace: Cape Charles, Va. (Town, county, and state)
10. Usual occupation: Truck Driver
11. Industry or business

FATHER
12. Name: Wesley Square
13. Birthplace: Cape Charles, Va.

MOTHER
14. Maiden name: Hettie Sunkins
15. Birthplace: Cape Charles, Va.

16. Informant: Deceased
Address

17. Burial (Burial, cremation, or removal, Which?) Date thereof 6-12-46 (month) (day) (year)
Cemetery or crematory: Mt. Calvary Bapto. National
Location: Anne Arundel Co. Md.
18. Funeral director: William A. Jackson
Address 916 Penna. Ave. Balto. 1, Md.

19. 6/7 (Date rec'd by registrar) 19 46 Albert R. Swankhan Deputy Local Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 7, 19 46 at 2.50P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 8, 19 46 to June 7, 19 46 and that I last saw him alive on June 7, 19 46

Immediate cause of death	DURATION
Pulmonary Tuberculosis	July 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Reuben Hoffman, M.D. M. D. or other
Address Henryton, Md. Date signed 6/7/46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 9-45-15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

05877

Reg. Dist. No. 75

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Carroll
City or town: Alesia (Rural)
(If ontside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 year
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Alesia (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Elsie I Stine

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	widow

6.(b) Name of husband or wife: Winfield Stine
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 21 1881

8. AGE:

Years	Months	Days	If less than one day
64	11	3	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: Jarrett Merryman
13. Birthplace: Md
MOTHER 14. Maiden name: Martha Marsh
15. Birthplace: Md
16. Informant: Mrs Wm. Ramon
Address: Hampstead Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 26/46 (month) (day) (year)
Cemetery or crematory: Grave Run
Location: Balto Co Md
18. Funeral director: Edw C Tipton
Address: Hampstead Md
19. June 24 1946 Mrs. W. G. L. Demuth (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1946 at 5-30 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 12 1946 to June 24 1946 and that I last saw h alive on June 22 1946.

Immediate cause of death	DURATION
Coronary Occlusion	Suddenly
Due to: Cirrhis-Selerotic Cardio-Renal Vascular disease.	?
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Joseph E. Bush MD
M. D. or other
Address: Hampstead Md Date signed 6-24-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

CERTIFICATE OF DEATH

★ 05878

Reg. Dist. No. 24

1. PLACE OF DEATH:

County: Carroll

City or town: Sykesville (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4yrs-6mo-9da.

Hospital, institution, or street address where death occurred: Springfield State Hospital

How long in hospital or institution? 4yrs--6mo--9da

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County:

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No.: Monkton (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Martha Hettie Tingle

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
female	white	single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): September 21, 1864

8. AGE: Years	Months	Days	If less than one day
81	8	30	hrs. min.

9. Birthplace: Delaware (Town, county, and state)

10. Usual occupation: none

11. Industry or business: none

FATHER — 12. Name: John Tingle

FATHER — 13. Birthplace: Delaware

MOTHER — 14. Maiden name: K. Clogg

MOTHER — 15. Birthplace: Delaware

16. Informant: Hospital Records

Address: Sykesville, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 25, 1946 (month) (day) (year)

Cemetery ~~or crematory~~: Laurel Hill Cemetery

Location: Philadelphia, Pa.

18. Funeral director: Wm. J. Tiekner & Sons

Address: No. 4 Pa. Ave. Baltimore 17, Md.

19. June 21 (Date rec'd by registrar) 19 46 C. Gray Ellen Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 20, 1946, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10, 1942, 19..., to June 20 1946 and that I last saw her alive on June 20 1946

Immediate cause of death	DURATION
General Arteriosclerosis	5 years.
Due to:	
Due to:	
Other conditions: Psychosis with Cerebral Arteriosclerosis (Include pregnancy within 3 months of death)	5 years

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: Dr. Maud M. Rees, M. D. or other

Address: Sykesville Maryland Date signed: 6-20-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

05879

Reg. Dist. No. 78

1. PLACE OF DEATH:
County: Carroll
City or town: Near New Windsor
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 mos.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Carroll
City or town: Near New Windsor
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R. D.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Maytelle Warfield

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	C	Widowed

6.(b) Name of husband or wife: Adam Warfield
Deceased 6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 24, 1880

8. AGE: Years	Months	Days	If less than one day
65	5	7	hrs. min.

9. Birthplace: Frederick Co - Maryland
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business
FATHER 12. Name: John F. Hammond
13. Birthplace: Maryland
MOTHER 14. Maiden name: Diana Grey Linnard
15. Birthplace: Maryland
16. Informant: Mrs. Jennie White
Address: 16 Spring St. Hudson. N. Y.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-5-46 (month) (day) (year)
Cemetery or crematory: Fairview
Location: Cross Corner, Carroll Co. Md.
18. Funeral director: E. M. Walt
Address: Mt. Joy Pa.
19. 6-4- 1946 (Date rec'd by registrar) E. M. Farver Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 1st 1946, at 9.45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 18 1946 to June 1 1946
and that I last saw her alive on June 1 1946

Immediate cause of death	DURATION
Myocardial degeneration	
Due to: with mitral insufficiency	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. H. Legg M. D. or other
Address: Union Bridge Date signed 6-2-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

05880

Reg. Diat. No. 80

1. PLACE OF DEATH:
County: Carroll
City or town: New Windsor R. D.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: New Windsor R. D.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Jennie Watson

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1878

8. AGE: Years: 68 | Months | Days | If less than one day: ..... hrs. ..... min.

9. Birthplace: Not Known (Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business

FATHER
12. Name: Not
13. Birthplace: Known

MOTHER
14. Maiden name: Not
15. Birthplace: Known

16. Informant: John Nugent
Address: New Windsor, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 27-1946 (month) (day) (year)
Cemetery or crematory: Western Chapel Cem.
Location: Westminster, Md R. D.

18. Funeral director: H. D. Hartsler & Sons
Address: Union Bridge & New Windsor, Md

19. June 27 1946 (Date rec'd by registrar) Evans J. Burdett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 24 1946, at 9:00 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary disease	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James T. Mook Deputy Medical Examiner
M. D. or other
Address: Westminster Md Date signed: 6/24/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Diat. No. 76 05881

1. PLACE OF DEATH:
County Carroll
City or town Westminster RD I
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 40 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Carroll
City or town Westminster RD I
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Henry Willet

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Jane (Study) Willet
6.(c) If alive, give age 76 years

7. Birth date of deceased (mo., day, yr.) December 5 1866

8. AGE:	Years	Months	Days	If less than one day
	79	6	28	hrs. min.

9. Birthplace Adams County Penna.
(Town, county, and state)
10. Usual occupation Farming
11. Industry or business Farm

FATHER
12. Name Henry Willet
13. Birthplace Adams County Penna.

MOTHER
14. Maiden name Mary Stair
15. Birthplace Adams Coynty Penna.

16. Informant Mrs Edw. Plumber
Address Westminster, Md. RD I

17. Burial (Burial, cremation, or removal. Which?) Date thereof June 5 1946 (month) (day) (year)
Cemetery or crematory Union Cemetery
Location Silver Run Md.
18. Funeral director J. M. Little & Son.
Address Littlestown, Pa. Per P. A. L.

19. June 3 1946 (Date rec'd by Registrar) Ray Fogle Dep Clerk Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 1946 at 2 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1 1944 to June 3 1946 and that I last saw h alive on May 27 1946

Immediate cause of death (Enter only one cause per line for (a), (b), and (c).) DURATION
Cerebral hemorrhage
(a) Pressure
Due to senile dementia
(b)
Due to
(c)
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. Reese Workman M. D. or other
Address Westminster Date signed 6/4/46

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05882

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

CERTIFICATE OF DEATH

Reg. Dist. No. 79

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Carroll

City or town: Keymar-rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Carroll

City or town: Keymar, rural

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs. Celia M. Winemiller

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: George H. Winemiller

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 24, 1872

8. AGE: Years	Months	Days	If less than one day
74	3	21	..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Charles Harner

13. Birthplace: Pa.

MOTHER — 14. Maiden name: Amelia Gettier

15. Birthplace: Pa

16. Informant: George H. Winemiller

Address: R.D. Keymar, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: June 18, 1946. (month) (day) (year)

Cemetery or crematory: Methodist

Location: Middleburg, Md.

18. Funeral director: C.O. FUSS & SON

Address: TANEYTOWN, Md.

19. June 18 1946 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15, 1946, at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 27 1946, to June 15 1946

and that I last saw her alive on June 14 1946

Immediate cause of death: Cerebral Arteriosclerosis

	DURATION
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: J. N. Legg M. D. or other

Address: Union Bridge Date signed: 6-15-46

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

05883

★ Reg. Diat. No. 75

1. PLACE OF DEATH:
County: Carroll
City or town: Rural near Millers
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 years
Hospital, Institution, or street address where death occurred:
How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Carroll
City or town: Rural near Millers, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: John Wesley Wisner

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): Oct. 17. 1926

8. AGE:	Years	Months	Days	If less than one day
	19	7	28	hrs. min.

9. Birthplace: Baltimore Co. Maryland
(Town, county, and state)
10. Usual occupation: Farme Labor
11. Industry or business

MOTHER FATHER
12. Name: William K. Wisner
13. Birthplace: Baltimore Co. Md.
MOTHER
14. Maiden name: Catherine Kedrick
15. Birthplace: Baltimore Co. Md.

16. Informant: William K. Wisner
Address: Millers Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-18-46 (month) (day) (year)
Cemetery or crematory: Cemetery
Location: Forest Baltimore Co. Md
18. Funeral director: Jacob Whinkle Sons
Address: Manchester Md.

19. June 16 1946 (Date rec'd by registrar) Mrs M. P. S. Demmer Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: June 15 1946, at 9:00 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary occlusion	minutes
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: James T. Monroe Deputy Medical Examiner
M. D. or other
Address: Westminster Md. Date signed 6/15/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

05884

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 53

CERTIFICATE OF DEATH

Reg. Dist. No. 76

1. PLACE OF DEATH:
County Carroll
City or town Near Westminster — Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 76
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md County Carroll
City or town Westminster — Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Ernest Wolf.

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Susie Wolf.
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17 1870

8. AGE: Years	Months	Days	If less than one day
76	4		..... hrs. ..... min.

9. Birthplace Carroll Co. (Town, county, and state)
10. Usual occupation Farmer
11. Industry or business
FATHER 12. Name Peter Wolf.
FATHER 13. Birthplace Germany
MOTHER 14. Maiden name Mary E. Rawlins
MOTHER 15. Birthplace Germany
16. Informant Mrs Susie Wolf
Address Westminster Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof June 30-46 (month) (day) (year)
Cemetery or crematory Trinity Lutheran Cem.
Location Carroll Co.
18. Funeral director H Bankard & Son
Address Westminster Md.
19. 6/25 19 46 L.L. Woodward Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 19 46 at 1:00 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 19 46 to June 28 19 46
and that I last saw him alive on June 27 19 46

Immediate cause of death	DURATION
Carcinoma of Nose and	
Septic Rh. Arthritis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None Date of op.
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide No Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James T. Shamer M. D. or other
Address Westminster Md Date signed 6/28/46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING